Bellevue Neurology
PATIENT DEMOGRAPHIC FORM

Name _____ Today's date __/___/__
Last First M.I.

Mailing Address _____ Age _____
Number, Street, Apartment Number

_____
City State Zip

Home Phone (____)_____ Work Phone (_____)_____ Cell Phone (_____) _____

Date of Birth _____/_____/_____ SS # _____ Marital Status _____ Gender _____

Employer_____ Retired:☐ Fulltime Student: ☐ Part Time Student:☐

Spouse's Name: _____ Employer _____ Work # _____

Person to notify in case of emergency _____ Phone (_____)_____
(Please list a person not living in your home)

Referring Doctor _____

May we leave a message on your home answering machine? □Y □N
May we leave a message for you at work to call us? □Y □N
May we discuss your medical condition with another person? □Y □N

If yes, whom _____ Relationship _____

How did you hear about our practice? _____
****

Policy Holder (if different from patient or responsible party) _____

Policy Holder's Date of Birth _____/____/_____SS#_____

Employer of Policy Holder _____ Work Phone(_____)_____

Patient's Relationship to Policy Holder _____
****

If patient is a minor please enter responsible party information. (Note: We do not bill absent parents, the adult presenting the minor for care is the responsible party.)

Name _____ SS# _____
Last First M.I.

Address _____
Number, Street, Apartment Number

_____
City State Zip

Home Phone (_____)_____ Work Phone (____)_____ Cell Phone (_____)_____
****

PLEASE PRESENT THIS FORM WITH YOUR INSURANCE CARD AND DRIVER'S LICENSE/GOVT ID TO THE RECEPTIONIST

Bellevue Neurology

Roopa Bhat, MD, PhD
2020 NE 116th Ave, Suite 100
Bellevue, WA 98004

Name: _____ Home/Cell Phone: _____

Street Address: _____ Work Phone: _____

City, State, Zip: _____ Email: _____

(For appointment reminders, Emails are never sold or distributed)

Date of Birth: _____ /_____ /_____

Social Security #: ____-____-_____

Referring Physician: _____

Primary Care Physician (PCP): _____ (a copy of your evaluation may be sent to your PCP unless you check this box: ☐ Don't copy PCP)

PCP Office Address: _____

PCP Office Phone: _____

CHIEF COMPLAINT: What is the main symptom that caused you to make this appointment today?

_____

HISTORY OF PRESENT ILLNESS: Please describe briefly when and how your symptoms began and how they've progressed here_____

_____

_____

_____

PAST MEDICAL HISTORY: Please list any previous or current illnesses and treatments/dates

☐ Diabetes ☐ High Blood Pressure ☐ Stroke ☐ Heart disease ☐ High Cholesterol

☐ Thyroid ☐ Depression/Anxiety ☐ Cancer ☐ Asthma/COPD ☐ Other (List)

_____

_____

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CURRENT MEDICATIONS: Use back of this sheet if additional space is needed.

Medication Name	Dosage (mg)	How many times per day do you take?

MEDICATION ALLERGIES:

Medication/Substance	Reactions (e.g. rash, hives, wheezing)

SURGICAL, PREGNANCY, AND INJURIES: Please provide description and approximate date/year.

Surgeries _____

_____

Major Injuries _____

_____

Pregnancies _____

FAMILY HISTORY: Please list any illnesses in your family members especially those that are relevant to your current problems.

_____

_____

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SOCIAL HISTORY:

Marital Status_____

Occupation _____

How much do you weigh? _____

What is your height? _____

Do you/have you ever abused substances?____

Do you smoke cigarettes?

☐ Yes ☐ Quit ☐ Never

Packs/day?
____

Do you drink alcohol?

☐ Yes ☐ Quit ☐ Never

☐ Daily?

HAVE YOU HAD ANY OF THESE TESTS?

	Test	When?	Where?
☐	MRI/CT brain		
☐	MRI/CT spine		
☐	EEG		
☐	EMG		
☐	Carotid Artery		
☐	Echocardiogram		
☐	Spinal Tap		

ANYTHING ELSE YOU WOULD LIKE TO TELL THE DOCTOR?_____

_____

_____

THIS NEXT SECTION FOR PATIENTS WITH MIGRAINES ONLY (FILL OUT BELOW):

How many days a week do you now have headaches:_____Location of the head:_____

Accompanying symptoms (circle one/more): sensitivity to light/sound, flashing lights, rainbow colors, dizziness

Triggers (circle all): insomnia/stress/specific foods/alcoholic beverages/perfumes/lights/neck pain/hormones

Abortive meds previously tried (circle one/more):
imitrex/amerge/maxalt/zomig/relpax/sumavel/zembrace/onzetra/frova/Excedrin/caffeine
Pills/nasal spray/shots/creams

Daily meds previously tried (circle one/more):
nortriptyline/topiramate/valproate/Depakote/gabapentin
blood pressure meds like propranolol/verapamil/lisinopril

Other treatments: Botox/nerve blocks/acupuncture/massage/physical therapy/chiropractor

Bellevue Neurology

Roopa Bhat, MD, PhD
2020 NE 116th Ave, Suite 100
Bellevue, WA 98004

Patient Name:_____ **Date:**_____

REVIEW OF SYSTEMS: Please check any items that you are experiencing or have experienced recently.

General
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever/chills
- ☐ Night Sweats
- ☐ Loss of Appetite
- ☐ Fatigue/Tiredness
- ☐ Weight Gain/Loss
- ☐ Nervous/Anxious
- ☐ Depression
- ☐ Sleep Disturbance

Eyes
- ☐ Blurring
- ☐ Double Vision
- ☐ Vision Loss
- ☐ Eye Pain
- ☐ Sensitivity to Light

Ear/Nose/Throat
- ☐ Ear Pain
- ☐ Ringing in Ears
- ☐ Decreased Hearing
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Difficulty Swallowing
- ☐ Difficulty Tasting
- ☐ Difficulty with Smell

Genitourinary
- ☐ Incontinence
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Urinary Frequency
- ☐ Male – Erectile Dysfunction
- ☐ Female – Heavy periods
- ☐ Female – No periods

Neurological
- ☐ Paralysis
- ☐ Weakness
- ☐ Numbness/Tingling
- ☐ Fainting
- ☐ Tremors
- ☐ Imbalance
- ☐ Vertigo
- ☐ Memory/Concentration Problems

Heart/Lungs
- ☐ Chest Pain
- ☐ Chest Pressure
- ☐ Heart Palpitations
- ☐ Leg Swelling
- ☐ Cough
- ☐ Shortness of breath

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in Bowel Habits
- ☐ Heartburn
- ☐ Choking spells
- ☐ Gas/Bloating
- ☐ Rectal Bleeding

Neck/Head
- ☐ Headaches
- ☐ Swollen Neck/Glands
- ☐ Stiff/Tender Neck
- ☐ Dentures/Partials

Psychiatric
- ☐ Suicidal Thoughts
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Stress

Extremities
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Weakness
- ☐ Stiffness
- ☐ Arthritis
- ☐ Rash
- ☐ Itching

Other
- ☐ Heat/Cold Intolerance
- ☐ Excessive Thirst/urination
- ☐ Abnormal Bruising/prolonged bleeding
- ☐ Hives
- ☐ Recurrent Infections
- ☐ Speech problems
- Seizures

Bellevue Neurology
Patient Consent/Financial Policy

INSURANCE COVERAGE AND FINANCIAL POLICY

Our billing office will bill your insurance for your visit for a plan in which the practice participates. Please bring your insurance card(s) and identification with you to each appointment. The amount for which you are responsible (any deductibles, copays, percentages or non-covered services) is required at the time of service. You are responsible for knowing the specific rules of your insurance carrier. Bellevue Neurology is contracted (in-network) with several insurance carriers, however, if we are not contracted with your insurance carrier, you may be required to pay a higher fee than if you were seen by a contracted (in-network) provider. If you do not have one of the plans with which the practice is contracted, the total cost of your visit is required at the time of service. If at any time you are concerned about the cost of a visit, you may ask for someone from the business office who will be happy to discuss the cost with you.

MANAGED CARE REFERRAL PROCESS

Your plan may require a referral from your primary care physician (PCP) to be on file with them before seeing a specialist. If a referral is required, it is your responsibility to work with your PCP to obtain this referral before your appointment. If Bellevue Neurology is unable to verify that your insurance carrier has a referral on file, your appointment will be rescheduled or if you are seen without a valid referral, all charges will be your responsibility.

PAYMENT OF POST VISIT BALANCES

All post-visit balances must be paid within 30 days of when the balance becomes the patient's responsibility and a statement from Bellevue Neurology is received. If you have any questions regarding your statement or outstanding balance you may contact our billing specialist at (253)588-7911.

CANCELLATION/RESCHEDULING

Your appointment reserves a time especially for you. Because we make every effort to see patients on time, we do not overbook or double-book to accommodate patients who do not keep their appointments. Therefore, the practice charges $50.00 for missed appointments that are not rescheduled or cancelled with at least one business day's notice.

COMPLETION OF OUTSIDE PAPERWORK

Bellevue Neurology will charge a Processing Fee of $25.00 (+) $5.00 per page to complete Outside Paperwork outside of your appointment time. This includes Disability Forms and FMLA Paperwork. Payment is required in advance and paperwork will not be processed until payment is received. Please allow one week for paperwork to be completed.

AUTHORIZATION OF CARE

I grant permission for Bellevue Neurology to render such care that my physician may deem necessary in my diagnosis and treatment. I understand that such care may include medical treatment and minor surgical procedures.

HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have be given or offered the Bellevue Neurology HIPAA Notices of Privacy Practices.

Patient Name: _____ _____ _____ _____

Signature of Patient or Representative | *Relationship to Patient | Date

*If the patient is unable to sign this agreement or is a minor, I am entering into the agreement on behalf of and as the legally authorized representative of the Patient.

Revision 10/14/2016